

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Policies Protect Against Compliance Failures

Physicians concerned about a compliance audit may want to consider new insurance policies that indemnify physicians against losses resulting from a government audit and an investigation for erroneous billings, allegations of false claims, or charges of fraud.

The risks physicians face resulting from a federal audit of their billing practices are significant, says Stephen Shepherd, vice president of the medical insurance division of Geo. F. Brown & Sons Inc., an insurance consultancy, in Chicago. Brown manages the compliance assurance program (CAP), which provides coverage in the event of a loss. Often, the losses from risks physicians face could exceed what many practices could pay, so an insurance policy that protects against such losses would be a worthwhile investment.

Taking Cover

The cost of defending a physician in a fraud case could range from \$100,000 to more than \$1 million, experts say. "In addition to paying legal fees for discovery, preparation, and court room appearances, the physician also must pay an expert to review charts and testify at court," says Joseph Feltes, a senior health attorney with Buckingham, Doolittle & Burroughs LLP, in Cleveland. "The total litigation expense package to defend a civil false claims action, for example, could exceed \$300,000." What's more, legal fees in a protract-

ed case could exceed \$750,000, experts say.

A policy providing at least \$1 million in coverage may be needed if a physician is audited, says Shepherd. This amount should be enough for a physician to hire a competent legal defense team and pay most costs in a case involving lengthy litigation, experts say.

The typical malpractice policy, which most physicians have, provides coverage of only \$25,000 to \$50,000 in the event of an audit. Most of these policies would be inadequate for providing coverage in a fraud case. In fact, some malpractice policies provide no coverage in fraud cases.

"I wouldn't be surprised if a physician's malpractice carrier declined to offer coverage for that physician if he or she becomes the target of a governmental investigation for alleged improper coding or billing practices," says Feltes. "In that scenario, the physician must absorb all legal expenses, which could mount up quickly and significantly, especially if the physician is unable to reach a settlement and is forced to litigate."

For a policy that provides competent coverage, a practice could pay between \$1,500 and \$3,000 per physician per year, and that coverage can differ among policies, Shepherd says. For example, attorneys working on behalf of the physician could be paid directly from the policy; if not, the physician would have to pay the attorneys and wait for reimbursement.

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Defined Contribution Plans Create Options

National health spending rose by 6.9% in 2000, a recent government report says. It was the largest percentage increase since 1993. The report's chief author, Katharine R. Levitt, director of the National Health Statistics Group for Medicare and Medicaid Services, identified two main reasons for the surge: resistance to managed care among physicians, hospitals, and consumers; and Congress' decision to restore funds previously cut from Medicare, which accounts for 17% of health care spending.

Consumers prefer less restrictive forms of managed care, which are more costly than HMOs, says Levitt. One type of these consumer-preferred forms is the defined contribution plan. In this plan, employers pay a set amount for each worker and offer various options, including HMOs and traditional health plans. Workers pay the difference between what the employer pays and the cost of their plan of choice. Annual deductibles can be as high as \$3,500.

Another type of plan involves high-deductible insurance coverage with a medical spending account. Employers pay money into a special spending account, an amount that is usually less than what a worker customarily spends on health care. The worker makes up the difference, ranging from \$250 to \$3,500 each year. This plan may be linked to an after-tax savings account.

These "consumer-driven" health plans require workers to pay more out of their own pockets, so the success of these plans depends on consumers being willing to gamble that they will stay well. William M. Mercer Inc., benefits consultants in New York, reports that 29% of large employers are willing to try such plans. In January, Textron Inc., in Providence, R.I., launched a defined contribution plan. The plan has a simple strategy: no gatekeepers, no copayments, and no referrals, George Metzger, a Textron vice president, told *The Wall Street Journal*. The plan gives workers freedom of choice, but it also puts them in charge of spending health care dollars wisely. Medtronic, a medical-device manufacturer in Minneapolis, also has introduced a defined contribution plan.

These types of plans are likely to turn health care into a commodity, as consumers shop for the lowest price or for the best combination of price and value. If a large number of Americans join these plans, physicians will have to become more cost-conscious and more efficient in their practices to remain competitive. Also, they will have to offer convenient, value-added services to keep patients as customers and may even have to bargain with patients to reach an acceptable fee, a scenario many physicians may find distasteful. It is too early to tell whether consumer-driven health care will control costs or simply shift costs from purchasers to consumers.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054
888/457-8800; Fax: 973/316-5989
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
Crystal Lake, Ill.

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Premier, Inc. and
Premier Practice Management
San Diego

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Minneapolis

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The Kaufman Group
Division of Superior Consultant Co. Inc.
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Sokolov Schwab Bennett
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Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

Automating Patient History Boosts Physician Productivity

By Richard L. Reece, MD, editor in chief

Taking a medical history is, for most physicians, the essence of being a medical doctor and the core of the physician-patient relationship. It's a medical skill that physicians learn as students, and for many physicians, it is more symbolic of their profession than the stethoscope. Taking a medical history has always involved certain variables, such as the complexity of the disease or condition, the mental acuity of the patient, and the physician's time. The time factor is affected by the method (dictation, electronic, or pen) that a physician uses to record the medical history.

Using technology to shorten the time required to take a medical history and produce a standardized record that facilitates coding would seem to make a lot of sense. But many physicians are reluctant to substitute traditional ways of practicing medicine for the efficiencies offered by today's technology.

Fostering Improvement

One company seeking to transform that reluctance is Primetime Medical Software, in Columbia, S.C., which markets the Instant Medical History, software designed to gather the medical history before the patient sees the doctor. The IMH (at www.medical-history.com) was developed in part by Allen R. Wenner, MD, a family practitioner in West Columbia, S.C.

"My goal was to design a clinical software system that would work in

the real environment of a physician's practice," says Wenner. "The software has more than 22,000 questions that center around 1,700 patient complaints. It can write a history on any problem seen in a typical physician's office, and no two histories are alike." Wenner is a practicing clinician at West Columbia Family Medicine, a four-physician primary care practice; and vice president of clinical applications design for Primetime.

Asking Questions

Wenner got the idea for the IMH in the mid-1980s, when he saw a patient for whom he could not determine a diagnosis. "I asked five colleagues to consult, and they couldn't figure out the patient's problem either," he says. "Then I sent the patient to the medical school at the University of South Carolina, where I am an assistant clinical professor of family medicine. The physicians there diagnosed her as having Sjogren syndrome, a disease of the immune system. I realized that they were able to determine her condition because all of the medical school clinicians—the medical students, residents, and attending doctors—had the time to spend asking her the right questions, while I did not.

"As a result of this experience, I looked for interview software to use in my practice," Wenner continues. "None existed, so I challenged my partner to help me develop software

to improve health care quality. I reasoned that by helping private practitioners access medical histories, they could better diagnose both difficult and routine patients."

Wenner also was driven to develop the software in response to an inconsistent pattern of information gathering he noticed in his own practice. "I discovered an inconsistency in the amount of patient information I gathered on Monday mornings versus Friday afternoons," he says. "After studying my practice patterns, I found out that on Friday afternoons, I asked an average of four questions, while on Monday mornings I asked an average of 13 questions for the same presenting complaint. The reason was simple: On Friday afternoons I was tired, and on Monday mornings I was fresh." In seeking consistency, thoroughness, and standardization of his patient information, Wenner realized that having software that collects data directly from patients would help to achieve this goal.

Regaining Lost Time

Physicians are taught in medical school to listen to their patients. Wenner has taken that truism one step further by having the computer "listen" to patients in a very directed way based on their chief complaint. "One study revealed that the average physician interrupts the patient 23 seconds after the interview begins," Wenner says. "Because of time con-

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Using technology to shorten the time required to take a medical history and produce a standardized record that facilitates coding improves consistency, thoroughness, and standardization of patient information.

(Continued from page 3)

straints, physicians feel they need to cut to the quick of what's wrong. We've lost that art of interviewing because of a bankruptcy of time. However, we can use technology to streamline the medical history process and improve the quality and efficiency of care."

For most physicians, having a computer take the medical history seems almost counterintuitive because the process involves the interaction of patient and computer, not patient and physician. Even so, the benefits of the process accrue to both the patient and

their Social Security number, and their birth date, so they don't make mistakes entering those data."

In addition, Wenner's patients have become accustomed to having real-time electronic processing of information in the exam room. "Some patients don't pay any attention to the process, but about 80% follow what I do right on the screen as I talk to them. They serve as a check on the accuracy of the information."

The software also improves physician efficiency. Editing the patient history, recording the findings, and

ware will never replace that. In addition, software can gather a great quantity of information, but some of it is extraneous. Gathering information this way is also time consuming for patients: It usually takes them about two and a half times longer than it would take me to enter the same amount of data. In addition, about one in seven patients has difficulty using the interview software."

Return on Investment

Despite these downsides, the IMH improves the business of medicine, Wenner contends. Using the software, a primary care physician who sees 25 patients a day can save four minutes on each patient visit for a total of 100 minutes saved per day, he notes. If the physician uses such time savings to add five more patients per day at an average charge of \$50 per visit, he or she would earn \$5,000 in additional revenue each month, or an additional \$60,000 a year.

"Such time savings are possible because all the physician has to do is edit the information that the patient has already entered," Wenner explains. "Typically, physicians must dictate records as part of their work flow. But the physician using automated medical history software does not need to spend time outside the exam room dictating the history." Automated medical history software cuts dictation time by 60%, saving about \$1,200 per physician per month, or \$14,400 a year, Wenner says.

"Overall practice efficiency increases because the physician is documenting services at the point of care," he notes. In the first 12 months, the system reduces personnel costs by about 30% and eliminates the rework required on claims by about 1.7 full-time equivalent employees per physician, Wenner says.

Another benefit of on-the-spot documentation is that it allows for a more complete record of visit information, an important requirement for Medicare reimbursement. Many

Automated medical history software cuts dictation time by 60%, saving about \$1,200 per physician per month, or \$14,400 a year.

**—Allen Wenner, MD,
West Columbia Family Medicine**

the physician, says Wenner. "Our software empowers patients," he explains. "It allows patients to give to their physician the information that the patients really want to make sure the physician has. What's more, it allows the physician to get to the heart of what their patients' complaints and issues really are."

Benefits Accrue

In Wenner's practice, patients are given a laptop computer when they enter the waiting room and are asked to enter requested data on a touch screen. Involving patients in this way not only allows them to make productive use of their time while they are waiting to see their doctor, it also improves the accuracy of the information in the medical record, Wenner says. "We found that by having patients enter their own demographics, we cut the error rate from 10% to less than one half of 1%," he says. "Patients know how to spell their name correctly, where they live,

examining the patient are accomplished within 12 minutes, notes Wenner. "By using the software, I am able to have a conversation with the patient rather than rushing out to dictate information obtained from the exam or worrying about even remembering all of it," says Wenner.

But access to data may be the most important benefit. "Physicians need more data on their patients' conditions," Wenner asserts. "If we get that data from the patients, we can better diagnose and treat them because we know the essential facts and are free to listen. Medical histories comprise about 70% of the medical record, and having the patient enter the history not only ensures that the information is complete, it also eliminates transcription and helps save time spent dictating and charting."

Still, the system is not perfect. "The gold standard of information gathering is the thorough clinical interview conducted by an experienced clinician," Wenner says. "Soft-

physicians undercode their services due to lack of documentation or out of fear of a Medicare fraud and abuse audit, losing potential revenue in the process.

Improved Documentation

“Physicians are being grossly underpaid for handling patients with complex conditions simply because data are not being recorded,” says Wenner. “However, the software is able to document additional data about basic treatments during the patient visit that the physician would never put down due to time constraints. The only way to justify charges is for documentation to be clear and complete; through the use of the software, physicians are able to document the full range of what has transpired during a patient visit. This function ensures that physicians will get paid for their work. When third-party payers see extensive documentation, they are more likely to reimburse for a higher level of services.”

Primetime surveys of physician practices indicate that physicians have raised the number of “level four” (the higher reimbursement) codes from 14% to 42% of all submissions on difficult, complicated patients.

“Billing at this level represents an additional \$48,000 in revenue for the practice—and it’s perfectly ethical and legitimate because it accurately reflects the work really being done by the physicians,” observes Wenner. “Such coding support is particularly important in documenting the treatment of complex patients with multiple problems.”

By having the patient help to create the electronic record, physicians can reap significant cost savings as well. “Redoing work, creating referral letters, and typing dictation all produce tremendous labor costs,” Wenner says. “The only way we can displace the current health care labor costs—which run between 70% and 80% in most clinics,

Many EMRs Offered

Many software programs exist for creating electronic medical records (EMRs) and for gathering medical histories. Some of the companies offering such programs include the following.

- Primetime Medical Software, in Columbia, S.C., provides more information on the Instant Medical History software discussed in this article at <http://www.medicalhistory.com>.
- Datamed Forms & Software Inc., in Deerfield Beach, Fla., markets EMR software called Dr. Notes. The EMR data are gathered by nurses and front-office staff. More information is available at www.drnotes.com.
- 21st Century Eloquence Inc., in West Palm Beach, Fla., markets the Eloquent Physician, EMR software. Physicians enter data into the system using either voice activation or a keyboard and mouse. More information is available at www.eloquentphysician.com.
- Qmeda Inc., in Arden, N.C., has a patient-based medical information system designed to help physicians and staff gather patient information. The EMR is not patient-generated, and report modules cover specialized areas (such as breast examinations) as well as procedure-specific modules (such as cardiac catheterization). More information is available at www.qmeda.com.
- Physician Micro Systems Inc., in Seattle, offers EMR software called Practice Partner Patient Records. Its EMRs are not based on patient-generated data. PMSI offers other software applications aimed at appointment scheduling and billing. More information is available at www.pmsi.com.
- ProVox Technologies Corp., in Roanoke, Va., provides a speech recognition-based system called TalkNotes that physicians can use to build an EMR by dictating into customized modules. More information is available at www.provox.com.

including physicians’ salaries—is to foster patient participation.”

Some physicians are not ready to allow patients to participate in creating their medical record. But Wenner asserts that many of these physicians will see the value in such systems after they see the increases in practice profitability that can be achieved. “We’ve demonstrated a revenue increase of \$20,000 per physician per month, and 7% of charges are no longer missed,” he says. “Those are powerful results.”

“Currently, only about 3% of physicians have a working electronic record,” Wenner adds. “Furthermore, very few have electronic records that

operate at the point of care. Rather, they have automated charting systems in which they dictate information that is stored electronically. This is like having a mule team pull a train car. Let’s start using the real train engines.

“It’s clear that technology is coming to the exam room,” Wenner continues. “The sooner physicians adopt information technology, the happier they’re going to be in their practice, the better care they are going to give their patients, and the more money they’re going to make.”

—Edited by Paula Grant, in Lincoln, Va.
More information on physician practice strategies is available on our Web site (see page 16).

Groups Seek to Improve Operations

High-performance physicians continually explore ways to improve the operational efficiencies of their practices. While most medical practices focus on cutting expenses to improve operating efficiencies, high-performance physicians focus on ways to gain economies of scale through various consolidation or centralization opportunities in the practices. In attempts to do more with less, these practices also explore other initiatives, such as group purchasing and changing the mix of personnel.

Interestingly, high-performance physicians typically have more support staff than the average medical practice, since these physicians view staffing as an investment in human resources.

High-performance practices use cost allocation methodologies to determine the true cost of providing direct and indirect patient care services. These practices review costs on the following bases: fixed versus variable, direct versus indirect, and clinical versus nonclinical. The basis on which these costs may be allocated varies from patient visits and encounters to work relative value units. Whenever high-performance physicians consider adding a new service or making changes to or eliminating an existing service, they are likely to do a cost-benefit analysis. Administrators in these practices

want to know the true cost of providing a particular service.

Many of the most useful technological tools available today address the need to improve medical recordkeeping and manage documentation. Aside from the obvious benefits associated with electronic medical records (EMRs), simple dictation of chart notes is one method for physicians to be more productive, since dictating is faster than handwriting. Dictation

also generates chart documentation that is legible and comprehensive, improves quality of care, and better supports CPT-4 coding, since physicians tend to overcode for what they document and undercode for the services that they actually provide. Some systems available today help to simplify dictation processes.

In its publication *Performance and Practices of Successful Medical Groups, 2000 Report Based Upon 1999 Data*, the Medical Group Management Association (MGMA) reports that highly productive medical groups provide programs for their employees to optimize staff productivity by focusing on formal training programs, cross-training of employees, exit interviews to detect potential problems, timely and meaningful performance evaluations, employee recognition or awards, and bonus opportunities based on group profitability.

High-performance practices also seek to optimize the mix of personnel in the practice, by using mid-level providers in lieu of recruiting additional physicians, for example. Mid-level providers, such as nurse practitioners and physician assistants, can

optimize physician productivity. These practices also continually monitor the practice's payer mix in order to make efficient use of patient scheduling and often seek ways to improve the flow of patients within the office.

For any group making operational improvements, one of the most important areas to evaluate is physician compensation. Better performing medical practices tend to link compensation to each physician's

As new computer-savvy physicians enter the work force, integrating technological tools into practices is essential.

personal production. While production can be based on patient visits or encounters, many private practice physicians link physician production, and therefore compensation, to a percentage of collection. A system known as work relative value units is becoming an increasingly popular method of physician compensation, since it focuses only on physician production and does not address issues related to business office activity regarding collections or a practice's operating expenses.

Pay for Performance

Interestingly, physician compensation plans that use gross charges to measure production may be making a comeback. Also, about 21% of medical groups were using adjusted charges in 2000. (Adjusted charges are gross charges minus payer discounts, MGMA says.) At the same time, the percentage of groups using collections to measure productivity fell to approximately 49% in calendar year 2000.

Despite the trend toward using gross or adjusted charges to compensate physicians, most physicians affiliated with high-performance practices are

John W. McDaniel is president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. This article is the fourth in a series of articles on high-performance physicians. For more information regarding profitability profiles of high-performance physicians, readers may contact McDaniel by phone at 800/764-2633, or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).

Many high-performance physicians will not hesitate to use systems that ease the regulatory and paperwork burden.

concerned with collections and, furthermore, compensating based on work relative value units detailed on a collection basis. This approach tends to be more accepted by physicians, since some physician compensation plans become extremely complicated, particularly plans dealing with the allocation of various expenses unless all physicians can reach agreement, which can be extremely difficult and in some practices impossible. Most physicians can agree, however, on direct physician-specific or personal expenses (such as continued medical education), equal share expenses (such as rent and utilities), and expenses that are allocated on a production basis (such as percentage of medical supplies used).

Seeking Value

Just as many practices disagree on compensation formulas, many also argue about how much to invest in information systems. Among high-performance practices, however, there may be fewer arguments on this issue. Many of these groups continually evaluate information technology solutions in an effort to improve operational efficiency, such as exploring ways to implement EMRs, either as a stand-alone system or in conjunction with an existing practice information system. Furthermore, more physicians today are using personal digital assistants (PDAs) to capture charges at the point of care, write prescriptions, comply with coding and documentation rules, gather reference materials, assist in making clinical decisions, facilitate continuing medical education, and help with physician scheduling. Indeed, as new technology-dependent physicians enter the workforce, integrating technological tools into practices is essential.

In many practices, simple, targeted solutions, not comprehensive complex systems, are used to improve productivity. Many physicians will not hesitate to embrace technologies that ease the regulatory and paperwork burden, ensure compliance, and increase productivity.

C. Everett Koop, MD, the former U.S. Surgeon General, has said that physicians have three basic choices. They can work harder and earn less, they can retire, or they can embrace information technology. Dubbed the three Rs of modern medical practice—retreat, retire, or retool—these choices are reminders that the groups that are most concerned about success will use information technology to do more with less. ■

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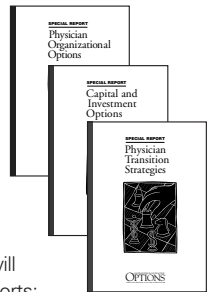
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Physicians Need Support to Survive

Many physicians believe that low reimbursement rates under capitation have caused many medical groups to close. In truth, most of the groups that are failing are closing their doors because of poor business management, says Michael Alper, president of Meridian Health Care Management, a managed care management services organization in Woodland Hills, Calif.

Physician organizations, particularly in California, have struggled financially in recent years. "Many claim that capitation rates are insufficient to cover the cost of care and are driving provider groups out of business," Alper says. To be sure, capitation may require more management resources than other forms of reimbursement, experts say. But when groups fail, it is likely that group management is to blame, not the capitation system, Alper adds.

Aligning Incentives

"These failing organizations also lack the management expertise, technology, administrative infrastructure, aligned interests, and effective compensation and incentive programs to succeed," Alper explains. "While some provider organizations have gone bankrupt, other groups in the same markets are doing well."

Alper offered his comments at the 2001 Healthcare Financial Management Association Conference of the San Diego chapter last fall. Alper is responsible for overseeing all components of Meridian Health Care Management's operations. In addition, he works directly with physician clients on organizational development, managed care operations, and strategic planning.

Although anecdotal evidence seems to suggest that health plans and physician groups are stepping away from capitation, the model will survive in

one form or another in the future, Alper believes. "As a result, provider organizations must continue to re-analyze their business operations, restructure their processes, and come up with strategies for improved performance under risk contracting," he notes. In fact, capitation is still a relatively new model of reimbursement, Alper points out. "Weaker groups have been weeded out, and stronger groups endure," he says. These stronger groups are better equipped and more experienced and thus will have more success with capitation in the future.

Reasons for Failure

There are lessons to be learned from the financial failures of medical groups. "For some groups, capitation is inadequate to cover the cost of health care services, but there are

signed up for contracts with low rates, thinking they would later make up for any losses through volume or economies of scale. But unless a group has a long-term strategy to maintain adequate capital resources through negotiation, operations, and retained earnings, the organization can quickly become financially overextended."

Information technology with sophisticated reporting systems can provide the financial data needed to analyze the viability of a managed care contract. "These systems not only analyze past data, but generate predictive data upon which financially viable capitation contracts can be based," Alper states. "Key business statistics exist to improve a group's bottom line, but they must be made available in a format management can act upon."

In recent years, many groups need-

When medical groups fail, many blame low capitation rates; but it is likely that group management is to blame, not the reimbursement system, says Michael Alper of Meridian Health Care Management.

myriad other causes of financial hardship," Alper says. Usually, groups tend to fail because of ineffective approaches in several of the following areas: capitalization, alignment of interests, compensation programs, management expertise, and technology. Since all of these factors contribute to the success or demise of an organization, careful consideration must be given to each one, Alper says.

Capitalization. "In some cases, capitation is too low to cover the costs of care, but this is not the entire picture," Alper relates. "Many provider organizations that were in a rush to increase enrollment indiscriminately

ed to tap their capital reserves when the groups were hit by unexpected increases in costs and had inexperience in managing risk. "For instance, many groups did not expect such a large surge in pharmaceutical expenses," Alper says. "Increased pharmaceutical expenses forced many groups to incur significant losses until the beginning of the next contractual period, at which point many renegotiated to have the pharmacy risk shifted back to the health plan."

Health plans realize that their success depends on the survival of well-run physician organizations and are becoming more committed to paying

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actuarially sound rates that reflect the actual costs of care, Alper adds.

Aligning interests. Ultimately, a physician organization's financial success depends on motivating doctors and other providers to deliver care in a cost-effective manner, Alper says. "As self-serving as it may sound, monetary incentives are still one of the most effective ways to drive behavior," he explains. "How providers are paid will, in due course, affect the quality of care they deliver and the decisions they make to control costs."

Successful groups often tie financial incentives to cost control, productivity, quality of care and patient satisfaction, and referrals.

Controlling costs can be particularly difficult when dealing with managed care organizations. "Managed care has inadvertently increased administrative costs," Alper observes. "There are also other medical expenses to manage related to overall member utilization, referrals, length of hospital stays, and expensive and unnecessary procedures and tests." Long-term medical costs can be controlled through incentive programs that encourage early detection and treatment of illness, disease management programs, and illness-prevention programs, he adds.

The issue of physician productivity also can be a challenge for medical groups. "Providers must feel that the more productive they are in achieving effective outcomes and delivering efficient and cost-effective care, the more they will be compensated," Alper states.

When seeking to improve quality and patient satisfaction, medical group managers must recognize that customer service happens at the physician and provider levels, Alper says. "To ensure high ratings, many provider organizations give financial incentives to physicians who receive high ratings in quality of care and patient satisfaction," he adds.

To control referrals, some groups

Given that the success of health plans depends on the survival of well-run physician organizations, many health plans are paying actuarially sound rates.

use financial incentives to penalize physicians who send patients for excessive out-of-network care, Alper says. "Conversely, groups provide bonuses for a well-managed referral program," he adds.

Compensation programs. "In the past 10 years, physician groups have experimented with ways to adapt their internal compensation plans to the managed care reimbursement system, Alper explains. "These compensation programs run the gamut from straight salary to fee-for-service, capitation, productivity-based pay, gainsharing, quality-based approaches, and profit-and-loss programs," he says. "Some physician organizations have blended compensation schemes with both fixed and variable pay components."

These methods have met with varying degrees of success. "For example, most physician groups have learned that a straight salary program is not conducive to increasing physician productivity, controlling costs, or improving care in the long term," Alper says. "On the other hand, a fee-for-service system does not provide an incentive for physicians to control the delivery of services, which can lead to overtreatment, overutilization, and excessive referrals."

Performance-based compensation in the form of bonuses and increased monetary incentives is the only way an organization can directly influence physician behavior, Alper believes.

Any performance-based compensation program must be simple enough for all participants to understand. "Physicians should be able to recognize how to change behavior to directly affect their bottom lines," Alper asserts. "By clearly tying financial

interests to the group's managed care goals, physician members will rally around the medical management approach that leads to the organization's overall success and profitability."

When the program is being considered, physicians should be included in the development of the compensation program. "This not only creates a sense of ownership, but also cultivates physician leaders for the program, who will then be able to show other physicians how to make behavioral and practice changes to achieve optimal compensation," Alper explains.

A provider group working under a capitated contract should also use a capitation model to compensate physicians, Alper says. "This strategy provides a way for the group to fix its own expenses, and it also allows the group's providers to operate under the same financial objectives as the parent organization," he adds.

Management expertise. Skilled executive management for physician groups is difficult to find. "Some doctors can become good administrators, but for the most part physicians are not trained or prepared to run multi-million dollar organizations," Alper says. "Often, provider groups will fill board seats based on the desired representation of various specialists, but this strategy does not always result in having the best qualified people run the organization."

As a result, a group must approach executive recruitment in the same way that it would fill any position in the organization. "First, the group's physicians must define the skills needed and agree on a job description," Alper explains. "The organization should interview several candidates, check

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“Some policies state that there will be no coverage if there’s an allegation of a criminal act. The best policies, however, will defend against allegations of criminal acts until a provider is proven guilty in court.”

—Stephen Shepherd, Geo. F. Brown & Sons Inc.

(Continued from page 1)

Some policies provide coverage for a shadow audit, which a physician can use to validate or question allegations of fraud. Government auditors who are overworked and federal audit departments that are stretched thin often make mistakes when reviewing a physician’s billing practices. As a result, professional consultants who perform shadow audits may be able to help a physician uncover those errors and rebut the government’s findings, Shepherd says.

“The best policies pay directly for legal defense, use a panel of experienced attorneys, and provide top consultants to ensure the best result possible,” Shepherd adds. “These policies also pay as much as the policy allows for all fees, fines, and penalties assessed against a physician or other provider.”

Civil or Criminal?

When selecting insurance, physicians should ensure that the policy provides coverage for both civil complaints and criminal charges. No policy can be used to protect a practice once a criminal judgment is issued, however.

“It is common for government prosecutors to allege both civil and criminal acts,” Shepherd explains. “The law does not allow an insurer to insure against an actual criminal act. What’s more, some policies state that there will be no coverage if there’s an allegation of a criminal act. The best policies, however, will defend against allegations of criminal acts until a provider is proven guilty in court. Physicians should be sure to ask about this aspect of coverage when comparing insurance products.”

Some policies provide a source of income if health insurers or HMOs stop paying claims, says Shepherd. Sometimes, when the government makes a claim against a practice, health insurers stop paying all claims, cutting off a practice’s cash flow. “The best policies include denial coverage, thereby providing physicians with protection against a sudden, unexpected increase in the denial of claims,” he says. “This coverage will pay physicians the value of denied claims above the normal threshold and pay for the appeal of those denials.”

Market Growth

The government, which has investigative offices in every state, has been using sophisticated information systems to identify physicians who commit fraud and has relied on whistleblower, or *qui tam*, lawsuits to generate investigative leads.

Since the government has been targeting physicians over the past few years, compliance insurers have seen a sharp increase in demand for policies, says Ron Gillaspie, senior vice president for Boynton & Boynton, an insurance broker, in Fair Haven, N.J. Boynton & Boynton does underwriting for Lloyds of London, the large international insurer.

Policies offered through Boynton & Boynton cover physicians for as much as \$1 million in claims, and a policy would provide coverage against allegations of civil and criminal fraud, Gillaspie says. Like the CAP policy, a policy from Lloyds would allow a physician to use a team of consultants to minimize risks by

conducting a shadow audit and by providing for attorneys experienced in such cases.

Interestingly, some insurers require that the covered physician implement a compliance program before coverage becomes effective. “We won’t insure without a compliance program, but we offer a program that includes a compliance program and the insurance for less than either could be purchased alone,” Shepherd says.

Risk Management

Physician risk from compliance issues is relatively new, Shepard says, and chiefly related to two federal laws passed since the mid-1980s: the False Claims Act amendments of 1986, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. “Under the 1986 amendments, a whistleblower who turns in a physician for false claims is allowed to keep up to 30% of monies recovered,” he notes. A whistleblower could be anyone who currently works for a physician, has worked for a physician, or is familiar with a physician’s billing procedures and alleges wrongdoing by reporting the wrongful practices to a state or federal investigating agency.

Under these and other laws, the federal government has been collecting large settlements from physicians, according to *Reducing Health Care Fraud*, a report issued last year by the Taxpayers Against Fraud, a nonprofit public interest organization in Washington, D.C. The government collected \$1.5 billion in civil fraud recoveries from all market sectors last year, the report says. Of that amount, \$1.2 billion (or 80%) resulted from

qui tam lawsuits, which begin when a whistleblower initiates a claim of fraud. In health care fraud cases alone, the government collected \$840 million, the report says. The average award paid to whistleblowers in lawsuits filed in medical cases under the False Claims Act is more than \$1 million, Shepherd says.

In addition to seeking damages under the False Claims Act, the government also has been successful in pursuing fraud cases under HIPAA. While HIPAA addresses many areas relating to health insurance, it also helped establish the health care fraud and abuse program run by the federal Department of Health and Human Services, Shepherd says. HIPAA authorizes HHS to take money out of Medicare to fund investigations of physicians. In 1996, the federal government spent \$176 million on fraud investigations. In 2000, it spent \$1 billion, he adds.

Errors and Omissions

Physicians who have put a compliance program in place to guard against fraud have found that the program may help them avoid making simple billing mistakes that can lead to significant losses. If the government finds improper billing under the False Claims Act, it may require a physician to pay three times the amount that was billed incorrectly and pay \$5,500 to \$11,000 per false claim, Shepherd explains.

"When you apply that pay-back formula to physicians and other health care providers who are easily sending out 100 or more bills a day, it can be a very substantial penalty—in the millions—certainly exceeding what a physician can comfortably afford," Shepherd says.

Improper billing doesn't necessarily indicate an intention to defraud the government or any other payer. An error could involve an innocent mistake in documentation that fails to support the level of coding that was

Questions to Ask Before Buying Insurance Coverage

Before purchasing insurance for compliance losses, physicians should ask at least the following questions:

- What does the policy cover? Does it cover government investigations for allegations of fraudulent billing for Medicare and Medicaid, and allegations of improper billing by commercial payers, such as HMOs? Does it cover violations of the Stark laws, HIPAA, the False Claims Act, and the Emergency Medical Treatment and Active Labor Act?
- Which insurer provides the coverage, and what is its rating? Seek an insurer that has a rating of B+ or higher from Standard & Poors, a rating agency in New York, and A.M. Best & Co., in Oldwick, N.J.
- Does the coverage provide access to consultants for compliance-oriented issues? Are you required to have a broker-approved compliance program in place? How much help will the broker or insurer provide if you need to implement a compliance program? Are you required to have an audit done of your billing practices to get coverage?
- What does the coverage cost per physician? Is legal defense provided on behalf of the physician, or does the medical group pay the attorney's fees and seek reimbursement from the insurer?
- Who picks the attorney to represent you? Is retroactive coverage available for the period prior to the date of signing the policy? How far back does the coverage extend?
- Is there coverage for issues that develop from self-reporting, which means the physician voluntarily informs the government of errors? The law requires that a provider return monies overpaid and to provide the government with notice of self-reported errors.

—DK

selected when recording patient care, or simply the use of the wrong code.

Many attorneys charge that Medicare regulations and the monthly carrier updates represent such a contradictory set of rules that no individual could reasonably be expected to follow them. "It's almost impossible for individual physicians to keep up with the Medicare regulations," says health attorney Amy Woodhall, of Walter & Haverfield in Cleveland. The newsletter the government sends to Medicare providers on changes and updates to federal reimbursement regulations can sometimes be as many as 50 pages, she says.

Given the complexity of federal reimbursement rules and the prob-

lems physicians can have in complying with these regulations, many experts agree that it is worth the time and effort to implement a compliance program and to have compliance insurance. "If you lose Medicare and Medicaid, you can no longer function," Shepherd says. "Under agreements the government has reached with physicians found guilty of compliance failures, the physicians have been prohibited from participating in these public programs. It's a huge personal liability, and you don't want to put everything on the line," he says.

—Reported and written by David Kettlewell, in Akron, Ohio. More information on physician practice strategies is available on our Web site (see page 16).

“Web-enabled processes eliminate long waiting times and follow-up calls for information. As a result, these systems go a long way toward improving the satisfaction of physicians and patients.”

—Michael Alper, Meridian Health Care Management

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references, and be prepared to later evaluate and reward performance.”

Beyond operations and financial management, these leaders need to develop and communicate an effective and compelling vision, motivate physicians and staff to perform at consistently high levels, and serve as a bridge for the multiple parties who have an interest in the group's performance, Alper notes.

“Leaders must be able to champion the group's overall goals and foster direct and honest communication throughout the organization,” Alper observes. “These leaders should explain the rationale behind new systems and changes. They should also let physician members know how they will be affected personally by these changes. Having gone through significant changes over the last several years, health care professionals are wary of yet another revolution. As a result, effective management will allow members the opportunity to comfortably let go of age-old routines, understand the need for change, and gradually become accustomed to new processes and new systems.”

Technology. Historically, the health care industry has underinvested in information technology that would help to boost the bottom line, Alper says. “In the past, provider organizations implemented systems inappropriate for managing the intricacies of managed care,” he claims. “For instance, they tried to incorporate practice management systems not designed for the management activities of a physician group.”

Until recently, integrated solutions also were not available. “Organizations had to cobble together systems

that addressed only one or two tasks in their management process,” Alper notes. “In addition, provider organizations, already capital poor, could not afford to invest in the software, hardware, and information technology professionals that were needed to design, deploy, and maintain a group management system.”

Today, provider groups need appropriate technology tools and Internet capabilities to help them negotiate, track, and manage capitated contracts successfully. “The system should specifically be built for managing a managed care network of physicians and incorporate all administrative functions, such as verifying member eligibility, processing referrals and authorizations, and submitting and processing claims,” Alper explains.

Also, the system should have a proven track record of success and, since so many health care organizations use different applications, it must also be able to interact with various levels of technology.

But the most critical function of an information system is its ability to interpret and analyze data, Alper says. “Better information and data analysis will help provider organizations in several ways,” he explains. “They will be able to obtain timely financial and utilization data to determine whether the costs of the services they provide are in sync with the revenue they receive. By analyzing information, provider groups can obtain data on cost trends, patterns, and abnormalities. Leadership will then be empowered with the business intelligence to directly influence the group's bottom line.”

Recent improvements in technolo-

gy have made systems more accessible to provider groups. “Application service providers (ASPs) allow these organizations to access state-of-the-art information technology as a hosted application or over the Internet without having to buy, license, or install expensive software programs in-house,” Alper says. The monthly subscription rates for ASP technology can be affordable.

Connecting Electronically

“The Internet and online connectivity have allowed provider organizations to electronically connect physicians to health plans and payers,” Alper says. “In this way, physician offices can submit claims and verify eligibility over the Internet, as well as receive immediate feedback on referrals and the status of claims. These Web-enabled processes eliminate long waiting times and follow-up calls for information. As a result, these systems go a long way toward improving the satisfaction of physicians in the group and patient members of the health plan.”

The availability of online systems also provides physicians with quick access to information, such as online lists of specialists and providers, up-to-date member eligibility, and limited benefit information. “Today's ASP solutions provide a whole host of services and tools that can make workflow much more streamlined on a routine, daily basis, resulting in efficient and cost-effective group management,” Alper says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Surgeon Says Collaboration Helps Physicians, Hospitals Succeed



Kenneth Cohn, MD, MBA, is a consultant with the Cambridge Management Group, a management consulting firm in Cambridge, Mass. Cohn was associ-

ate professor of surgery and chief of surgical oncology at the Veteran's Administration Hospital in White River Junction, Vt., and associate professor of surgery at Dartmouth Medical School in Hanover, N.H., before he earned his MBA at the Tuck School of Business at Dartmouth College. He maintains his clinical skills by providing general surgical coverage in New Hampshire and Vermont. In this interview, he discusses how physicians and hospitals can work together more efficiently with Richard L. Reece, MD, editor in chief.

Q: Why did you pursue an MBA degree?

A: I had been interested in earning an MBA since 1994, when President Clinton's health plan was vetoed and market forces took over. In addition, I had seen an article in *USA Today* that said only 75 people had earned both MDs and MBAs, so adding a business orientation to medical knowledge seemed like a promising new career. I went to business school with the idea of bringing information back to my

physician colleagues about the business of health care.

Because the Tuck School had no executive MBA program, I attended the program for two years, full time. During the summer and on vacations, I maintained my clinical skills by covering surgical practices.

Q: What is the focus of the Cambridge Management Group?

A: The Cambridge Management Group is a group of five senior consultants, and each one has had 25 years of experience in health care. The firm offers management consulting, but the area for which we are most well known is communication. We help hospitals and physicians resolve communication problems.

In the past, physicians and hospitals were able to work independently, and in the fee-for-service environment everyone made money. But today's environment of managed care and decreasing reimbursement mandates that hospitals and physicians work interdependently, rather than independently. Our firm helps physicians and hospitals achieve those goals.

I am the only physician in the firm. On the basis of my physician background, I can communicate and connect with physicians in a way that is different from the way other consultants can.

Q: Is there a cultural gap between hospitals and physicians? If so, how do you close that gap?

A: We have certainly noted a difference in perspective between physicians and administrators. However, some administrators do feel comfortable working with physicians and regard them as important allies.

We try to close the cultural gap by connecting with the individual people involved. We try to understand their issues, which usually involves learning a long history. Sometimes, a contentious situation will arise, and it will trigger memories of situations 10 years past that were not well handled. We help the physicians to move forward by having them articulate a vision for what they see as the future of health care in their community, and translating that vision into a language or a group of policies that can be put into operation by the administrators.

Q: How do you get physicians on a medical staff to work together in their own collective best interest and the best interest of the hospital at the same time?

A: Balancing the interests of the physicians and the interests of the hospital is sometimes a tough line to walk. The way to strike that balance is to recognize that everybody is there to serve the interests of the patient. That viewpoint involves changing the compact from what it used to be.

In the past, physicians looked to the hospital for protection from some of the market forces that affect

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In the past, physicians looked to the hospital for protection from some of the market forces that affect income. But by trying to focus on the interests of the patient, physicians and administrators can find common cause for working together.

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income. But by trying to focus on the interests of the patient, physicians and administrators can find common cause for working together. We try to start on small issues so that we can achieve some quick wins, and hope that the momentum of success carries through to some of the more contentious problems to be resolved.

Q: *Your company uses an organizational approach called the “structured dialogue.” Can you tell us about that, please?*

A: The structured dialogue is a technique that recognizes that the physicians who are closest to the patient are the ones who are the most likely to be able to understand that patient’s needs, both in the present and in the future. Therefore, physicians are best able to articulate a vision for future hospital investments.

We start by getting to know the CEO and the constraints that he or she faces. We also work closely with the vice president of medical affairs to get some idea of the talents of the physicians who admit patients to the hospital. We then pick two co-chairs, who in turn select approximately nine to 11 physician colleagues to serve on the medical advisory panel.

Panel members are respected and trusted by their colleagues. They are usually people in their 30s or 40s, although there have been some who are older but who still remain young in their thinking. They want to stay in the community, make a name for themselves, and leave a legacy to the hospital. Therefore, they are willing to work on a panel that will give them an

ability to shape the vision for the future of health care in their community. Usually we can identify relatively quickly the physicians who are willing to commit to the panel in return for assurance that their input will have an effect on the hospital’s direction.

Q: *What is the process for prompting change that the medical advisory panel undertakes?*

A: The panel meets for about a month to get background information from the administrators on issues of nursing care, information technology, and market demographics.

Next, physicians from all the major departments and sections issue a written report based on a questionnaire that details a number of important topics, such as the members of the department, their ages, their succession plan, and their views of what their department does well and what they would like to improve. Each department then gives a 15-minute presentation to the panel of the highlights from their report, followed by 15 minutes of questions and discussion.

After the department physicians leave the room, the panel members rate the presentation on a variety of different criteria. All panel presentations are generally completed over a four-month period. Then, based on the information gathered from the presentations, the medical advisory panel writes a consensus report highlighting what it believes to be the most important issues facing the community and what strategies should be undertaken to address these issues. In effect, the medical

advisory articulates clinical development priorities for the hospital.

The report is shared with administrators and collaboratively revised. The report is then presented to the hospital executive committee, members of the physician community, and finally to the board of the hospital. At one of our client institutions, when the medical advisory panel co-chairs presented the panel’s report to the board, the panel members got a standing ovation. So this is work that does improve the hospital’s ability to serve the community.

Q: *Sometimes hospital administrators find it hard to relinquish control over strategic planning. How do they react to allowing physicians to have some control over this process?*

A: Usually they specify some criteria for physicians to follow. For example, an administrator may designate a limited amount of money to be spent on new programs. Some note that if the physicians can identify some areas where supply costs can be decreased, then additional money will be available to put toward new programs. One medical advisory panel was able to identify supply cost savings amounting to \$800,000, which were then applied to the development of new programs.

Q: *Who finances the medical advisory panel?*

A: Financing is handled in different ways. In some cases, the physicians serve on the panel voluntarily. Other hospitals agree to pay the physicians for their time. Financing is usually left for the panel

Some administrators note that if the physicians can identify areas where supply costs can be decreased, then additional money will be available to put toward new programs. One medical advisory panel was able to identify supply cost savings amounting to \$800,000, which were then applied to the development of new programs.

Hospital administrators know that change can be implemented more rapidly if physicians are involved in owning and championing it rather than if the administrators try to push their own vision on the physicians.

to decide. Some panels feel strongly that they do not want to be beholden in any way to the hospital, while others believe it is reasonable to be compensated for time they are not spending on patient care.

Q: *What are some of the benefits of using a medical advisory panel to achieve change?*

A: The medical advisory panel is a group of physicians who are clinically active, and who come together in a project-based fashion and form a virtual team. When their work is done, they go back out into the community. As a result of their experience on the panel, they are much better educated, and they help their colleagues who have not been on the panel to understand the strategies the hospital needs to pursue.

A key element of success is that these physicians really feel bound to effect changes that will allow them to continue to practice in the hospital. They feel that getting involved in hospital strategy is in their best interest. Furthermore, hospital administrators know that change can be implemented more rapidly if physicians are involved in owning and championing it rather than if the administrators try to push their own vision on the physicians.

When physicians can drive the agenda, they are happy to become involved. Part of what leads individuals to a medical career is an aspiration to make a difference in health care. Some physicians are interested in learning leadership and strategic planning skills for this reason.

Administrators come and go, but physicians may stay in the hospital for 20 or 30 years. They constitute an

important, respected body of knowledge. At the same time, they have a record of experience, are close to the patients, and know what the patients are demanding.

Q: *How quickly do these physician leaders learn leadership skills and direction setting?*

A: Some of them learn these skills very quickly. One physician with whom I worked was a section chief of general surgery. He was promoted to section chief on the basis of his clinical skills, but once he attained that position, he recognized that he had a necessary but not a sufficient body of skills.

At the end of our working relationship, he said, "Physicians are not stupid. We just need to be trained." This physician didn't have the time to attend business classes, but his work in preparing his presentation to the medical advisory panel allowed him to learn how to analyze a profit and loss statement, to understand the economic aspects of care, and to develop effective leadership skills.

Q: *Why is it necessary to prepare physicians for leadership and participating in hospital-physician affairs?*

A: Physician preparation is necessary because physicians are simply not trained to participate in business-oriented strategic decision-making. Nothing in medical school has trained us for what we face now.

Medical school involves a lot of memorization and study on an individual basis. In business school, about 30% of my grade in every course was based on team projects. I've asked nearly 1,000 physicians how much of their grades in medical school came from team projects, and I have gotten

from every single one of them the same answer—zero.

Another example is communication style. In medical school, we learned a hierarchical style of communication, in which the attending physician talks to the residents, who then talk to the medical students. But most hospitals are matrix organizations, in which people are required to work together to achieve goals.

We also have to prepare physicians for team building. Physicians need to learn that a team cannot go from a "forming stage" to a "performing stage" without going through a storming stage.

Finally, physicians must learn to deal with issues of conflict resolution. Most physicians are very uncomfortable sitting down and talking about things they've done to make each other unhappy.

Physicians don't want to have their dirty laundry aired in a public setting. We help physicians learn how to get together, air their concerns in a constructive way, and move forward collaboratively.

We try to foster collaboration and leadership skills in a project-based setting. Physician leadership is the antidote to feelings of helplessness and disenfranchisement.

Health care is a very exciting field to be in right now. I love what I do. The current environment, while very challenging, can also be very rewarding for those physicians who develop skills that will allow them to lead the profession in uncertain times.

—*Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

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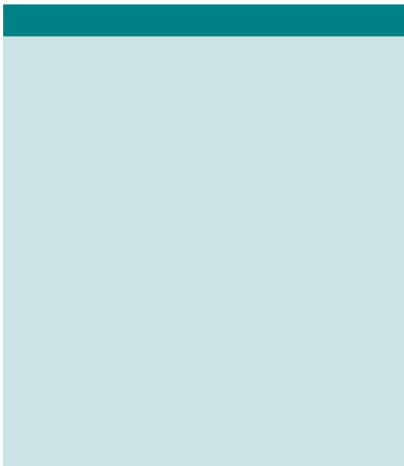
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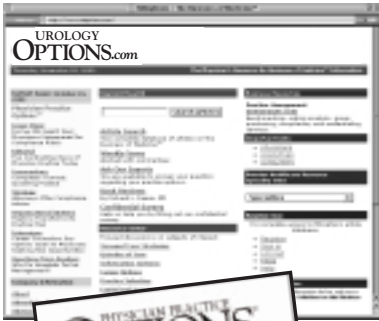


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